Medford School District 549C
815 S. Oakdale Avenue
Medford, Oregon 97501

Standard Health Care Plan for Food Allergy

Nursing Diagnoses: Ineffective Airway, Impaired Oxygen Saturation

Symptom	Action
• Itchy mouth • A few hives around mouth/face, mild itch • Mild nausea/discomfort	1. Give over the counter antihistamine if available. 2. Stay with student. 3. Notify parent. 4. Notify nurse and school health office personnel. 5. Locate Epi-pen for possible use. 6. Monitor Student. 7. If symptoms progress, see below.

Call 911 if:

Symptom	Action
If student has one or more of the following: • Shortness of breath • Wheeze (musical sound when breathing) • Repetitive cough • Paleness • Blue color • Fainting • Weak pulse • Dizzy • Confused • Tight or hoarse throat • Trouble breathing/swallowing • Swelling of the tongue or lips • Many hives all over body If a student has a combination of symptoms from different body areas: • Hives with mouth or eye swelling • Vomiting, crampy pain Any SEVERE SYMPTOM after suspected or known food allergy ingestion.	1. Inject Epi-pen immediately and note time. 2. Call 911. 3. Give over the counter antihistamine if available and student can swallow. 4. Give Rescue inhaler if available. 5. Notify parent. 6. Notify school health office personnel and nurse. 7. Monitor student 8. Have student lie on back with legs elevated if it doesn't obstruct breathing. 9. Repeat Epi-pen injection 5 minutes after 1st injection if no improvement and EMS has not arrived. 10. Perform CPR if student stops breathing or if heart stops beating.

Medications must be provided by parents and require a signed *Medication Administration Permission Form*. The school cannot supply medications. Students may carry their inhalers or Epi-pen with a signed parent's permission form. Inhalers must be brought to school with a current pharmacy label.

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Individualized Health Care Plan—Food Allergy

If you would like to develop an *Individualized Health Care Plan* for your student, please fill out the information below with signature and return to the school office. If an *Individualized Health Care Plan* is not returned to school, the *Standard Health Care Plan* will be in effect.

Student Name______________________________________ **Student ID** ________________**Grade**_____

School____________________**School Year**_______________ **Date of Birth** ___________**Bus/Walk**______

Parent/Guardian____________________________________**Phone Number**_________________________

Parent/Guardian____________________________________ **Phone Number**_________________________

My child has a Food Allergy to the following foods:	
Date of the last Reaction:	
Circle the symptoms your child shows when having a Food Allergy.	**Mouth:** Itching tingling, or swelling of lips, tongue, mouth **Skin:** Hives itchy rash swelling of the face or extremities **Gut:** Nausea abdominal cramps vomiting diarrhea **Throat:** Tightening of throat hoarseness hacking cough **Lung:** Shortness of breath repetitive coughing wheezing **Heart:** Weak pulse low blood pressure fainting pale blueness
In the event my child has a Food Allergy, do the following: (Place a check next to the appropriate direction)	____Call me. ____Administer antihistamine provided by Parent. **(All medications require a *Medication Administration Permission Form*)** ____Administer Epinephrine (Epi-Pen). Parent to provide Epi-pen. ____Have student self administer Epi-Pen. ____Call 911 and transport to ER.
My child has an Epinephrine prescription (Epi-Pen). The location of the Epi-Pen will be:	____In the school office (requires signed consent form by parent). ____Student will carry on person (requires signed consent by parent). **(All medications require a *Medication Administration Permission Form*)**
Special considerations and precautions (regarding school activities, sports, field trips, transportation/bus etc.):	

I give permission to the school nurse and other properly trained and authorized staff members of the Medford 549C School District to perform the tasks as outlined by my child's Individualized Healthcare Plan. I also consent to the release of the information pertaining to my child's care to staff members and those who may need to know this information to maintain my child's health and safety during the school day. **It is the parent's responsibility to provide medications.** If the health condition listed has changed I will inform my child's school or school nurse. This health care plan will be in effect while my student attends MSD.

Parent/Guardian signature:____**Date**__________________